Letters to the Editor

The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should:

- Include no more than 500 words of text, three authors, and five references
- Type with double-spacing
- See http://jtcs.ctsnetjournals.org/misc/ifora.shtml for detailed submission instructions.
- Submit the letter electronically via jtcvs.editorialmanager.com.

Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity to offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.

Central cannulation in acute aortic dissection repair

To the Editor:

We read with great interest the article by Reece and coworkers[1] on central cannulation for acute aortic dissection. We have also experienced the safety and the advantages of this technique, which we have routinely applied to 37 patients.[2]

The authors limited the application of this technique to one third of their patients. However, we think it could be routinely applied for type A dissection, as far as true channel antegrade perfusion is firmly established. There seem to be three prerequisites to establish reliable true channel perfusion invariably: safe cannulation, confirmation of true channel cannulation, and confirmation of antegrade true lumen perfusion.

First, safe cannulation with the Seldinger technique requires decompression of the cannulation site in advance, which could be induced pharmacologically, by insertion of femoral inflow, or by blood drainage from right atrial cannulation. In addition, a thin-walled flexible cannula with a spindle-shaped obturator and tapered dilators is indispensable.

Second, epiaortic ultrasound imaging helps to confirm the position of the tip of the cannula within the true lumen of the proximal arch. Epiaortic ultrasound provides more detailed information on the ascending aorta and proximal arch than does transesophageal echocardiography.[3]

Third, epiaortic color Doppler imaging provides real-time direct information on dynamic flow inside the false and true channels, which is effective for the assessment of antegrade perfusion via true lumen.

We congratulate Reece and colleagues on their outstanding results.

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2. Inoue Y, Ueda T, Taguchi S, Kashima I, Koizumi K, Takahashi R, et al. Ascending aorta cannulation in acute type A aortic dissection. *Eur J Cardiothorac Surg*. 2007;31:976-9.
3. Eltzschig HK, Kallmeyer IJ, Mihaljevic T, Alapati S, Shernan SK. A practical approach to a comprehensive epicardial and epiaortic echocardiographic examination. *J Cardiothorac Vasc Anesth*. 2003;17:422-9.

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Reply to the Editor:

We would like to thank Drs Inoue and Ueda for their kind comments regarding our publication on central cannulation of ascending aortic dissections. Since finishing this study, we have heard from multiple sources that they have used this technique for cannulation of ascending aortic dissections. In fact, just as Drs Inoue and Ueda describe, several groups have commented that this is their preferred method of cannulation for these patients. This collective experience further supports our notion that direct cannulation of the dissected ascending aorta can be done safely and is a viable option for surgeons operating on this difficult aortic disease.

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How should I cannulate my next acute aortic dissection?

To the Editor:

We read with interest the article by Reece and associates[1] supporting the feasibility and implying the potential advantage of direct cannulation of the dissected aorta